		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015032

Facility Name: Washington and Jane Smith Comm

Address: 2340 West 113th Place (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 779-8010 **Fax #** (773) 779-8648

IDPA ID Number: 362167948001

Date of Initial License for Current Owners: 09/06/96

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) Richard Sgarlata, C.P.A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd., Suite 300, Deerfield, IL 60015
(Telephone) (847)236-1111 Fax # (847)236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	185	Sheltered Care (SC)	185	67,525	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	101,835	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,967	21,225	1,859	32,051	8
9	SNF/PED					9
10	ICF	4,211	18,430		22,641	10
11	ICF/DD					11
12	SC	4,847	25,771		30,618	12
13	DD 16 OR LESS					13
14	TOTALS	18,025	65,426	1,859	85,310	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.77%

D. How many bed-hold days during this year were paid by Public Aid?
n/a (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
n/a

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 05/24/26

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 15 and days of care provided 1,792

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	420,490	3,876		424,366		424,366	(2,567)	421,799			1
2	Food Purchase		735,949		735,949	(21,444)	714,505		714,505			2
3	Housekeeping	141,807	52,920		194,727		194,727		194,727			3
4	Laundry	83,361	13,169		96,530		96,530		96,530			4
5	Heat and Other Utilities			289,089	289,089		289,089		289,089			5
6	Maintenance	352,681	11,571	182,286	546,538		546,538	(49,769)	496,769			6
7	Other (specify):*											7
8	**TOTAL General Services**	998,339	817,485	471,375	2,287,199	(21,444)	2,265,755	(52,336)	2,213,419			8
	B. Health Care and Programs											
9	Medical Director			12,015	12,015		12,015		12,015			9
10	Nursing and Medical Records	1,000,485	562,185	5,842	1,568,512		1,568,512		1,568,512			10
10a	Therapy			13,983	13,983		13,983		13,983			10a
11	Activities	141,869	23,565	1,040	166,474		166,474	(5,059)	161,415			11
12	Social Services	105,454		2,786	108,240		108,240		108,240			12
13	Nurse Aide Training											13
14	Program Transportation			2,032	2,032		2,032		2,032			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,247,808	585,750	37,698	1,871,256		1,871,256	(5,059)	1,866,197			16
	C. General Administration											
17	Administrative	310,121			310,121		310,121		310,121			17
18	Directors Fees											18
19	Professional Services			293,773	293,773		293,773	(66,474)	227,299			19
20	Dues, Fees, Subscriptions & Promotions			27,419	27,419		27,419	(3,618)	23,801			20
21	Clerical & General Office Expenses	368,652	38,706	14,152,980	14,560,338		14,560,338	(14,056,628)	503,710			21
22	Employee Benefits & Payroll Taxes			748,577	748,577	21,444	770,021	(7,880)	762,141			22
23	Inservice Training & Education			775	775		775		775			23
24	Travel and Seminar			9,342	9,342		9,342	(1,285)	8,057			24
25	Other Admin. Staff Transportation			1,990	1,990		1,990		1,990			25
26	Insurance-Prop.Liab.Malpractice			83,659	83,659		83,659	(232)	83,427			26
27	Other (specify):*											27
28	**TOTAL General Administration**	678,773	38,706	15,318,515	16,035,994	21,444	16,057,438	(14,136,117)	1,921,321			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,924,920	1,441,941	15,827,588	20,194,449		20,194,449	(14,193,512)	6,000,937			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington and Jane Smith Comm #0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			531,779	531,779		531,779	(30,609)	501,170			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			274,026	274,026		274,026	(274,026)				32
33	Real Estate Taxes			3,397	3,397		3,397	(3,397)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,806	9,806		9,806		9,806			35
36	Other (specify):*			7,416	7,416		7,416		7,416			36
37	**TOTAL Ownership**			826,424	826,424		826,424	(308,032)	518,392			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,984	151,266	233,250		233,250		233,250			39
40	Barber and Beauty Shops			56,542	56,542		56,542		56,542			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,114	52,114		52,114	(649)	51,465			42
43	Other (specify):*	1,234,755		74,749	1,309,504		1,309,504	(1,309,504)				43
44	**TOTAL Special Cost Centers**	1,234,755	81,984	334,671	1,651,410		1,651,410	(1,310,153)	341,257			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,159,675	1,523,925	16,988,683	22,672,283		22,672,283	(15,811,697)	6,860,586			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,025)	1		4
5	Telephone, TV & Radio in Resident Rooms	(22,876)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,672	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,618)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,736,850)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,811,697)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ ##########		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Washington and Jane Smith Comm

ID# 0015032

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Investment advisory fee	$ (45,390)	19	1
2	General-investment advisory fee	(13,527)	19	2
3	Community relations-salary	(75,010)	43	3
4	Marketing consultants	(13,965)	21	4
5	Admin-Public relations	(3,193)	21	5
6	General-Funerals	(414)	21	6
7	Realized Loss-General	(12,256,756)	21	7
8	Unrealized Gain/Loss-General	(1,670,204)	21	8
9	Securities cost	(390)	21	9
10	Directors and Officers Insurance	(7,880)	22	10
11	Assisted Living-Salaries and Wages	(511,193)	43	11
12	Dementia Care-Salaries and Wages	(648,552)	43	12
13	Life Care Podiatry expenses (Dementia)	(3,105)	43	13
14	Med. Serv.-Miscellaneous (Dementia)	(144)	43	14
15	Bldg & Gr-Apt-Repair & Maint.-Equipment	(1,081)	43	15
16	Bldg & Gr-Apt-Repair & Maint.-Paint	(276)	43	16
17	Bldg & Gr-Apt-Repair & Maint.-Plumbing	(947)	43	17
18	Bldg & Gr-Apt-Repair & Maint.-Building	(1,268)	43	18
19	Bldg & Gr-Apt-Refuse disposal	(1,768)	43	19
20	Heat Power-Apt. Utilities-Gas	(17,773)	43	20
21	Heat Power-Apt. Utilities-Electric	(1,410)	43	21
22	Heat Power-Apt. Utilities-Water	(1,830)	43	22
23	Bond Interest-Apt.	(37,298)	43	23
24	LOC Fees-Apt.	(5,762)	43	24
25	Misc. Bd Exp-Apt.	(2,087)	43	25
26	Out of state seminar	(1,285)	24	26
27	Bond fee expense	(13,570)	32	27
28	Apartment building depreciation	(43,281)	30	28
29	Apartment property taxes	(3,397)	33	29
30	Telephone income	(7,194)	21	30
31	Bazaar income	(5,059)	11	31
32	Interest income	(255,053)	32	32
33	Prior year legal fees	(3,788)	19	33
34	Unlocated legal invoices	(3,769)	19	34
35	Adjust off excess bed tax	(649)	42	35
36	Capitalized R&M	(26,893)	6	36
37	Rent on house	(5,400)	32	37
38	Voters poling place fee	(100)	21	38
39	Guest room and meals	(1,542)	1	39
40	Insurance refund	(232)	26	40
41	Photo sales	(30)	21	41
42	Copies	(1)	21	42
43	Batteries	(5)	21	43
44	Social security interest	(3)	32	44
45	Miscellaneous expense	(44,084)	21	45
46	Flowers	(253)	21	46
47	Film developing	(19)	21	47
48	Photogragher	(20)	21	48
49	**Total**	(15,736,850)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington and Jane Smith Comm **#** 0015032 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(2,567)	0	0	0	0	0	0	0	0	0	0	(2,567)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(49,769)	0	0	0	0	0	0	0	0	0	0	(49,769)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(52,336)	0	0	0	0	0	0	0	0	0	0	(52,336)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,059)	0	0	0	0	0	0	0	0	0	0	(5,059)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(5,059)	0	0	0	0	0	0	0	0	0	0	(5,059)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(66,474)	0	0	0	0	0	0	0	0	0	0	(66,474)	19
20	Fees, Subscriptions & Promotions	(3,618)	0	0	0	0	0	0	0	0	0	0	(3,618)	20
21	Clerical & General Office Expenses	(14,056,628)	0	0	0	0	0	0	0	0	0	0	(14,056,628)	21
22	Employee Benefits & Payroll Taxes	(7,880)	0	0	0	0	0	0	0	0	0	0	(7,880)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,285)	0	0	0	0	0	0	0	0	0	0	(1,285)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(232)	0	0	0	0	0	0	0	0	0	0	(232)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,136,117)	0	0	0	0	0	0	0	0	0	0	(14,136,117)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,193,512)	0	0	0	0	0	0	0	0	0	0	(14,193,512)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Washington and Jane Smith Comm **#** 0015032 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(30,609)	0	0	0	0	0	0	0	0	0	0	(30,609)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(274,026)	0	0	0	0	0	0	0	0	0	0	(274,026)	32
33	Real Estate Taxes	(3,397)	0	0	0	0	0	0	0	0	0	0	(3,397)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(308,032)	0	0	0	0	0	0	0	0	0	0	(308,032)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	(649)	0	0	0	0	0	0	0	0	0	0	(649)	42
43	Other (specify):*	(1,309,504)	0	0	0	0	0	0	0	0	0	0	(1,309,504)	43
44	**TOTAL Special Cost Centers**	(1,310,153)	0	0	0	0	0	0	0	0	0	0	(1,310,153)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,811,697)	0	0	0	0	0	0	0	0	0	0	(15,811,697)	45

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	$ 29,004	The Orthon Group		$ 29,004	$	1
2	V	22	Workman's comp insurance	87,110	The Orthon Group		87,110		2
3	V	26	Insurance	54,655	The Orthon Group		54,655		3
4	V	19	Investment	58,917	Heritage Capital		58,917		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 229,686			$ 229,686	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James J. Nemec	Board Member	President of the	None	None	10	25.00	Financial	$ 58,917	19-03	1
2			Board and owner					Services			2
3			of Heritage Cap.								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,917		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lasalle Bank		x	Building addition	Various	1991	$ 5,800,000	$ 5,800,000	07/01/26	2.7000	$ 216,296	1
2	American National Bank		x	Building apartment				750,025	09/15/02	3.8000		2
3												3
4												4
5												5
	Working Capital											
6	Comerica		x	LOC							29,964	6
7												7
8												8
9	TOTAL Facility Related						$ 5,800,000	$ 6,550,025			$ 246,260	9
	B. Non-Facility Related*											
10	Supplemental schedule										3,709	10
11	Interest income										(255,053)	11
12	Unrealized loss-Eddy Trust										5,084	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (246,260)	14
15	TOTALS (line 9+line14)						$ 5,800,000	$ 6,550,025			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington and Jane Smith Comm **#** 0015032 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington and Jane Smith Comm COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 185,004 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing facility	247,516	Pre 1994	$ 649,404	1
2					2
3	TOTALS	247,516		$ 649,404	3

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1924		$ 70,920	$	40	$	$	$ 70,920	4
5	57			1928	438,552		40			438,552	5
6	55			1958	429,080		35			429,080	6
7	50			1972	1,528,440	43,670	35	43,670		968,679	7
8	77			1992	4,868,578	139,102	35	139,102		1,112,816	8
	Improvement Type**										
9	Building Improvements			1972	307,827		20			307,827	9
10	Boiler and Ventilating			1974	48,223		20			48,223	10
11	Building Improvements			1975	91,428		20			91,428	11
12	Building Improvements			1978	205,755		20			205,755	12
13	Building Improvements			1980	102,046	5,102	20	5,102		101,684	13
14	Building Improvements			1981	31,819	1,591	20	1,591		30,228	14
15	Building Improvements			1982	53,600	2,680	20	2,680		48,240	15
16	Building Improvements			1983	163,759	8,188	20	8,188		139,196	16
17	Building Improvements			1984	187,160	9,358	20	9,358		149,728	17
18	Parking Lot			1984	3,580	179	20	179		2,864	18
19	Building Improvements			1985	26,309	1,315	20	1,315		19,729	19
20	Building Improvements			1987	149,405		10			149,405	20
21	Building Improvements			1989	81,658		8			81,658	21
22	Smith Wing Renovation			1989	150,364	9,004	17	9,004		101,532	22
23	Building Improvements			1991	160,090		8			160,090	23
24	Kitchen Remodeling			1991	931,139	26,604	35	26,604		226,160	24
25	Roof and Siding			1991	40,000	2,395	17	2,395		20,660	25
26	Building Improvements			1993	69,928	4,187	17	4,187		31,622	26
27	Fan Coil Project			1994	102,713	10,271	10	10,271		66,761	27
28	Building Remodeling			1995	52,983	5,298	10	5,298		30,009	28
29	Complete Fan Coil Project			1995	217,546	8,702	25	8,702		47,861	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof	1996	$ 14,045	$ 1,405	10	$ 1,405	$	$	37
38	Elevator	1996	28,857	962	30	962			38
39	Roof Repair	1997	118,147	11,815	10	11,815			39
40	Boiler Project	1997	96,589	9,659	10	9,659			40
41	Sidewalk Paving	1997	9,968	997	10	997			41
42	Gutter Replacement and Repairs	1997	3,886	389	10	389			42
43	Painting and Room Decorating	1997	24,159	2,416	10	2,416			43
44	Building Maintenance	1997	4,890	489	10	489			44
45	Window Repair and Replacement	1997	14,192	1,419	10	1,419			45
46	Heating and Plumbing	1992	7,248	518	14	518			46
47	Heating and Plumbing	1993	7,935	794	10	794			47
48	Heating and Plumbing	1995	5,575	558	10	558			48
49	Air Conditioner and Ventilating	1995	4,874	244	20	244			49
50	Telephone System	1996	22,211	2,221	10	2,221			50
51	Air Conditioner and Ventilating	1996	6,765	338	20	338			51
52	Security System	1997	14,872	2,125	7	2,125			52
53	Sprinkler System	1997	31,262	4,466	7	4,466			53
54	Air Conditioner and Ventilating	1997	28,183	1,409	20	1,409			54
55	Arts and Crafts Room Renovations	1998	9,232	923	10	923			55
56	Auditorium Renovations	1998	8,159	816	10	816			56
57	Boiler Project	1998	2,123	212	10	212			57
58	Elevator	1998	88,086	4,440	20	4,440			58
59	Heating and Plumbing	1998	7,259	290	25	290			59
60	Lighting Upgrade	1998	57,526	3,196	18	3,196			60
61	Phone System	1998	26,163	2,616	10	2,616			61
62	Roof Repair	1998	37,174	1,859	20	1,859			62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,192,282	$ 334,222		$ 334,222	$	$ 5,080,707	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,192,282	$ 334,222		$ 334,222	$	$ 5,080,707	1
2	Smoke Detectors	1998	6,312	631	10	631			2
3	Kitchen Remodeling	1998	6,413	641	10	641			3
4	Air Conditioner and Ventilating	1998	2,815	563	5	563			4
5	Air Conditioner and Ventilating	1998	2,687	269	10	269			5
6	Electrical Fixtures for Hallways	1998	1,106	111	10	111			6
7	Head Rails for Hallways	1998	1,494	149	10	149			7
8	Refrigerator	5/22/2000	2,075		20	104	104		8
9	Refrigeration/freezer	6/21/2000	1,428		20	71	71		9
10	Refrigeration/freezer	7/17/2000	865		20	43	43		10
11	Carpeting	12/18/2000	832		20	42	42		11
12	Carpeting	12/6/2000	572		20	29	29		12
13	Shade	10/25/2000	813		20	41	41		13
14	Carpeting	8/4/2000	685		20	34	34		14
15	Plumbing	11/17/2000	1,075		20	54	54		15
16	Painting-main dining room	8/18/2000	2,175		20	109	109		16
17	Paint	7/31/2000	584		20	29	29		17
18	Paint	7/26/2000	518		20	26	26		18
19	Irrigation system	5/22/2001	665		20	33	33		19
20	Paint	2/7/2001	587		20	29	29		20
21	Paint	3/22/2001	1,151		20	58	58		21
22	Boiler	2/20/2001	704		20	35	35		22
23	Shade	1/15/2001	1,037		20	52	52		23
24	Carpeting	4/6/2001	3,759		20	188	188		24
25	Air conditioning chiller	6/4/2001	1,952		20	98	98		25
26	Thermostat	1/4/2001	783		20	39	39		26
27	Waterproofing	6/1/2001	1,900	190	10	190			27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,237,269	$ 336,776		$ 337,890	$ 1,114	$ 5,080,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,237,269	$ 336,776		$ 337,890	$ 1,114	$ 5,080,707	1
2	Carpeting	10/1/2000	4,880	1,627	3	1,627			2
3	Vertical blinds	6/1/2001	1,211	242	5	242			3
4	Paint three floor corridors	4/1/2001	6,240	1,248	5	1,248			4
5	Paint kitchen	6/1/2001	3,535	707	5	707			5
6	Resident parking signs	8/1/2000	1,151	230	5	230			6
7	Plaster work	8/1/2000	4,152	415	10	415			7
8	Multi-purpose room	1999	8,834	442	20	442			8
9	Carpet in the front hallway	1999	7,756	388	20	388			9
10	AC Motor	1999	1,481	148	10	148			10
11	Elevator repair	1999	3,390	170	20	170			11
12	Asbestos encapsulation	6/1/2001	3,410	341	10	341			12
13	Replacement door	4/1/2001	1,019	51	20	51			13
14	Asphalt repair	5/1/2001	2,275	228	10	228			14
15	Tub supplies	6/1/2001	919	92	10	92			15
16	Tub supplies	6/1/2001	12	1	10	1			16
17	Renovations-2nd floor	10/1/2000	1,277	51	25	51			17
18	Renovations-2nd floor	11/1/2000	685	27	25	27			18
19	Renovations-2nd floor	6/1/2000	2,770	111	25	111			19
20	Renovations-2nd floor	1/1/2001	94	4	25	4			20
21	Renovations-2nd floor	3/1/2001	1,001	40	25	40			21
22	Tub supplies	6/1/2001	1,920	192	10	192			22
23	Renovations-2nd floor	2/1/2001	25,734	1,029	25	1,029			23
24	Tenant buildout	3/1/2001	3,903	781	5	781			24
25	Paint and patch hallways	11/1/2000	1,475	295	10	295			25
26	Floor covering	5/1/2001	1,050	105	10	105			26
27	Hydro-flushing of sewers	4/1/2001	785	76	10	76			27
28	Paint common areas	6/1/2001	429	85	5	85			28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,328,657	$ 345,902		$ 347,016	$ 1,114	$ 5,080,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,328,657	$ 345,902		$ 347,016	$ 1,114	$ 5,080,707	1
2	Roof boiler house and Smith	9/1/2000	9,800	327	30	327			2
3	Tuckpoint building	10/1/2000	32,440	1,622	20	1,622			3
4	Caulking-wing walls, elevators	10/1/2000	4,580	916	5	916			4
5	Renovations-2nd floor Beverly	2/1/2001	384	15	25	15			5
6	Pre-construction Beverly	5/1/2001	667	27	25	27			6
7	Campus master Beverly	12/1/2000	5,335	213	25	213			7
8	Renovation-2nd floor Beverly	12/1/2000	1,751	70	25	70			8
9	Renovation-2nd floor Beverly	9/1/2000	1,647	66	25	66			9
10	Renovation-2nd floor Beverly	12/1/2000	1,939	78	25	78			10
11	Building improvements	12/1/2000	5,000	200	25	200			11
12	Carpet	1/1/2001	4,541	454	10	454			12
13	Carpet	1/1/2001	4,419	442	10	442			13
14	Security camera	6/1/2001	1,836	262	20	92	(170)		14
15	Fireproof file safe	5/1/2001	8,119	541	20	406	(135)		15
16	Smoke detectors	10/1/2000	2,458	246	20	123	(123)		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,413,573	$ 351,381		$ 352,067	$ 686	$ 5,080,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 704,680	$ 58,740	$ 70,468	$ 11,728		$	71
72	Current Year Purchases	98,038	10,327	10,327				72
73	Fully Depreciated Assets	619,547	61,955	61,955				73
74								74
75	TOTALS	$ 1,422,265	$ 131,022	$ 142,750	$ 11,728		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing facility	1999 Ford Taurus	1999	$ 16,118	$ 2,303	$ 2,303	$	7	$	76
77	Nursing facility	1987 Ford F250 Pick-up	1998	7,300	1,043	1,043		7		77
78	Nursing facility	2000 Ford Goshen Bus	2000	45,104	3,007	3,007		7		78
79										79
80	TOTALS			$ 68,522	$ 6,353	$ 6,353	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,553,764	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 488,756	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 501,170	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,414	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,080,707	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment building	$ 487,975	$ 12,199	$ 32,766	86
87	Apartment building improvements	93,632	27,245	27,245	87
88	Apartment furniture & equipment	29,278	3,837	3,837	88
89	Land	112,500			89
90					90
91	TOTALS	$ 723,385	$ 43,281	$ 63,848	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [x] YES [ ] NO

16. Rental Amount for movable equipment: $ 9,806 Description: Copier 9,124; Postage meter 682
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 52,054	$		$ 52,054	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,786			1,786	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			97,426			97,426	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				51,338		51,338	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						30,646		30,646	13
14	TOTAL			$		$ 151,266	$ 81,984		$ 233,250	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Washington and Jane Smith Comm **#** 0015032 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 142,687	$	1
2	Cash-Patient Deposits	7,849		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,434,764		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,275		6
7	Other Prepaid Expenses	24,913		7
8	Accounts Receivable (owners or related parties)	532,752		8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,186,240	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	51,581,730		12
13	Land	7,214,543		13
14	Buildings, at Historical Cost	7,823,545		14
15	Leasehold Improvements, at Historical Cost	2,813,076		15
16	Equipment, at Historical Cost	2,301,085		16
17	Accumulated Depreciation (book methods)	(6,033,211)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,957,866		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 67,658,634	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 69,844,874	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 201,251	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,849		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	242,486		30
31	Accrued Taxes Payable (excluding real estate taxes)	(827)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,855		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	597,541		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,064,155	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,550,025		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,550,025	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,614,180	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 62,230,694	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 69,844,874	$	48

***(See instructions.)**

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 63,759,524	1
2	Restatements (describe):		2
3	See attached schedule	9,308,758	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,068,282	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(10,837,588)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (10,837,588)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 62,230,694	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,945,387	1
2	Discounts and Allowances for all Levels	114,929	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,060,316	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	260,133	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 260,133	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	59,069	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	7,194	15
16	Rental of Facility Space		16
17	Sale of Drugs	514,879	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	271,317	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 852,459	23
	D. Non-Operating Revenue		
24	Contributions	2,961	24
25	Interest and Other Investment Income***	4,532,631	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,535,592	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	126,195	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 126,195	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,834,695	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,287,199	31
32	Health Care	1,871,256	32
33	General Administration	16,035,994	33
	B. Capital Expense		
34	Ownership	826,424	34
	C. Ancillary Expense		
35	Special Cost Centers	1,599,296	35
36	Provider Participation Fee	52,114	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 22,672,283	40
41	**Income before Income Taxes (line 30 minus line 40)****	(10,837,588)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (10,837,588)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,838	1,950	$ 66,851	$ 34.28	1
2	Assistant Director of Nursing	1,816	1,891	40,650	21.50	2
3	Registered Nurses	11,755	12,245	234,250	19.13	3
4	Licensed Practical Nurses	11,240	11,708	159,466	13.62	4
5	Nurse Aides & Orderlies	64,027	66,695	477,458	7.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,875	1,950	28,272	14.50	9
10	Activity Assistants	17,064	17,746	113,597	6.40	10
11	Social Service Workers	11,583	12,066	105,454	8.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,492	10,912	126,578	11.60	14
15	Cook Helpers/Assistants	22,569	23,472	180,128	7.67	15
16	Dishwashers	13,658	14,204	113,784	8.01	16
17	Maintenance Workers	30,619	31,844	352,681	11.08	17
18	Housekeepers	18,949	19,707	141,807	7.20	18
19	Laundry	10,677	11,104	83,361	7.51	19
20	Administrator	1,875	1,950	88,400	45.33	20
21	Assistant Administrator	1,875	1,950	70,875	36.35	21
22	Other Administrative	2,700	2,808	150,846	53.72	22
23	Office Manager	1,659	1,725	50,143	29.07	23
24	Clerical	15,122	15,752	318,509	20.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,638	1,703	21,810	12.81	31
32	Other Health Care(specify)					32
33	Other(specify)	82,983	86,368	1,234,755	14.30	33
34	TOTAL (lines 1 - 33)	336,014	349,750	$ 4,159,675 *	$ 11.89	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,015	9-3	36
37	Medical Records Consultant	Monthly	4,176	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	241	13,983	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	1,040	11-3	44
45	Social Service Consultant	70	2,786	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	363	$ 34,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	72	1,666	10-3	52
53	TOTAL (lines 50 - 52)	72	$ 1,666		53

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gary Johanson	CEO	0	$ 110,000
Barb Fraser	CFO	0	40,889
Roy Eickman	Executive director	0	88,400
David Carroll	Assoc. exec. Director	0	70,832
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 310,121

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached	Legal	$ 41,704
Heritage Capital Mgmt	Investment mgmt	58,917
William E. Hay & Co.	Recruitment firm	12,645
FR&R	Accounting fees	74,060
DLM Financial Advisor	Accounting fees	22,892
Desmond & Ahern	Auditing	25,440
See attached	Computer services	35,427
Ameripay	Payroll services	22,688
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 293,773

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,111
Unemployment Compensation Insurance	4,290
FICA Taxes	303,468
Employee Health Insurance	106,600
Employee Meals	21,444
Illinois Municipal Retirement Fund (IMRF)*	
Pension expense	196,551
Disability insurance	6,034
Life insurance	6,216
Physical fitness program	18,119
Holiday expense	12,308
TOTAL (agree to Schedule V, line 22, col.8)	$ 762,141

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	505
(Indicate # of checks performed 72)	
Recruitment	8,619
Dues & subscriptions	14,677
Promotion-Page 5	3,618
Less: Public Relations Expense	(3,618)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,801

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,057
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 8,057

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington and Jane Smith Comm # 0015032 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Washington and Jane Smith Comm **#** 0015032 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN 10,212**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,265** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,606**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,444** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **FR&R** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.